NC Medicaid Managed Care
Provider Playbook

Fact Sheet
Provider Payment and Reimbursement

Understanding payment and reimbursement requirements for providers

NC DHHS establishes provider payment requirements for health plans that are intended to encourage continued provider participation in the Medicaid program, to ensure beneficiary access and support safety net providers, and to ensure continuation of current reimbursement levels using mechanisms that mitigate the risk of health plan steerage to other providers. Final capitation rates will reflect required reimbursement levels.

NC DHHS-established provider payment requirements for health plans are listed below.

CLAIM PAYMENTS

Rate Floor Claim Payments

Health plans are required to pay services identified as rate floors no less than 100% of the posted fee schedule rate unless the provider and health plan have agreed to an alternative rate or reimbursement methodology through provider contracts. The alternative reimbursement methodology may include a lesser of provision where the health plan would pay the lesser of the billed amount and the defined rate. An alternative reimbursement agreement is not required for health plans to pay more than 100% of the rate floor rate. Rate floor services can be identified as those with an asterisk (*) on the fee schedules.

Non-Rate Floor Claim Payments

Non-rate floor program service rates are negotiable between the health plans and providers. Providers should refer to their respective contracts with each health plan for the negotiated service rates.

Out of Network (OON) Claim Payments

If the provider has engaged in a good faith contracting effort with the health plan but the provider has refused that contract, then the health plan, after considering all facts and circumstances surrounding a provider's willingness to contract, may deem the provider as an out-of-network provider in accordance with the health plan's Good Faith Contracting policy. After prepaid health plan (PHP) evaluation based on their good faith contracting policy, a health plan is prohibited from paying an

OON provider at more than 90% of applicable Medicaid fee-for-service rate, inclusive of rate floor services.

NC DHHS has established OON policy flexibilities for the transition to NC Medicaid Managed Care. Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan policy flexibilities will be announced prior to launch. Health systems and providers are strongly encouraged to continue contract negotiations with health plans and finalize contracts to avoid reduced reimbursements.

Member Payments

Members may be required to pay a copayment to providers as defined in the State Plan. Outside of copays, providers may not bill Medicaid beneficiaries for:

1. Services covered by NC Medicaid, if the provider accepts the member as a Medicaid beneficiary; and
2. Services or goods NOT covered by NC Medicaid unless the beneficiary was notified in advance that the service is not covered by Medicaid and the beneficiary is financially responsible.

Please see the Provider Requirements related to Billing Medicaid Beneficiaries bulletin for more information.

MEDICAL HOME PAYMENT

Primary Care Medical Home Payments

Health plans will be required to pay per member per month (PMPM) primary care medical home payments for providers that meet Advanced Medical Home (AMH) standards. These payments will be equal to the payments providers receive today in the Carolina ACCESS program ($2.50 or $5.00 per beneficiary assigned to the practice).

Enhanced Medical Home Payments

Effective Dec. 1, 2022, through June 30, 2023, AMH tiers 1, 2 and 3 providers that are serving as the assigned primary care provider for NC Medicaid beneficiaries eligible for Tailored Care Management (TCM) will receive the enhanced medical home payment of $20 PMPM regardless of Aged, Blind and Disabled (ABD) status.

- AMH Tiers 1, 2, and 3 providers who serve as the assigned PCP for NC Medicaid beneficiaries eligible for TCM will receive the calculated PMPM difference between the current $5.00 ABD and $2.50 Non-ABD management fee payments to reach the $20 PMPM Enhanced Medical Home Payment. The Enhanced Medical Home Payments will not exceed $20 PMPM and are a separate funding stream from the current ABD and Non-ABD Medical Home Payments that are currently made today.

Continuation of the payment after June 30, 2023, is dependent on funding availability and may be tied to additional performance expectations for primary care engagement. More information can be found in the Enhanced Medical Home Payments for Advanced Medical Homes Serving Members Eligible for Tailored Care Management Medicaid bulletin.

CARE MANAGEMENT PAYMENT

Tailored Care Management (TCM)

Between Dec. 1, 2022 and September 30, 2023, TCM providers (AMH+ and Care Management Agency (CMAs)) will be paid a monthly standard rate when they provide TCM to assigned members in that month. TCM providers will submit a TCM claim to their respective LME/MCO for the first TCM contact of each month in order to receive the TCM rate.

Beginning October 1, 2023, TCM providers (AMH+ and CMAs) will be paid a monthly acuity based payment when they provide TCM to assigned members in that month. TCM providers will submit a TCM claim to their respective Tailored Plan for the first TCM contact of each month in order to receive the beneficiary's assigned acuity tier TCM rate.

More information can be found in the Tailored Care Management Data Specifications Guidance.

Local Health Departments (LHD)

Standard Plans will pay LHDs no less than the PMPM payments they receive today for the provision of Care Management for High-Risk Pregnancy (CMHRP) and Care Management for At-Risk Children (CMARC) during 2021 - 2024. These amounts are:

- CMHRP: $4.96 PMPM for all PHP member women ages 14 – 44 on Medicaid residing in the LHD county/service area
- CMARC: $4.56 PMPM for all PHP member children ages 0 – 5 on Medicaid residing in the LHD county/service area

PHPs will compensate LHDs / other providers of care management services at net mutually agreed upon rates beginning in 2025.

Tailored Plans will pay LHDs no less than PMPM payments they receive today for the provision of Care Management for High-Risk Pregnancy (CMHRP) from 2023 - 2024 for the same reimbursement amounts as above.

DIRECTED PAYMENTS

Health plans will be required to make additional payments above those built into the (PMPM capitated rate to certain providers, including, but not limited to in-network local health departments, faculty

physicians affiliated with the teaching hospitals for each University of North Carolina medical school and hospitals owned by UNC Health Care and Vidant Medical Center. DHHS calculates these additional, utilization-based payments on a quarterly basis with an annual reconciliation. DHHS will make payments to health plans outside the PMPM capitation rates to cover the cost of these additional payments.

WHAT IF I HAVE QUESTIONS ?

For general inquiries and complaints regarding health plans, NC Medicaid has created a Provider Ombudsman to represent the interests of the provider community. The Ombudsman will provide resources and assist providers with issues through resolution.

Provider Ombudsman inquiries, concerns or complaints can be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov, or received through the Provider Ombudsman line at 919-527-6666. The Provider Ombudsman contact information is also published in each health plan's provider manual.

For all other questions, please contact the NC Medicaid Help Center at 888-245-0179 or email at Medicaid.HelpCenter@dhhs.nc.gov